Authorization to Release Medical Records

Patient's Name: _____ **Birth Date:** _____

Parent's Name: _____ **Phone:** _____

Address: _____

Release: ☐ From ☐ To	**Release: ☐ From ☐ To**
Olympia Pediatrics 3434 12th Ave NE Olympia, WA 98506 (ph) 360-413-8470 (fax) 360-413-8819	Facility: _____ Address: _____ _____ Phone: _____ Fax: _____ Email: _____

Delivery Preference: ☐ Mail ☐ Fax (Max 50 pages) ☐ Secure Email ☐ Pick up at Olympia Pediatrics (if releasing to patient/parent/guardian)

Information Requested:

☐ Summary of Care (immunization history, medication list, problem list)

☐ Last 3 years of Chart Notes

☐ Records regarding the following diagnoses: _____

☐ Other: _____

Purpose of Request:

☐ Changing Practices ☐ Personal ☐ Treatment ☐ Payment/Billing ☐ Legal ☐ Other

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Notice of Privacy Practices to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I understand this authorization will expire 90 days from the date signed. I understand that a fee for copies may be imposed by the person(s)/organization(s) listed above.

Disclaimer: Per Washington State Law if the patient has reached their 14th birthday, only the patient may authorize disclosures relating to sexuality/reproduction, drug/alcohol use. If patient has reached their 13th birthday, only the patient may authorize disclosure related to mental health.

If over 13: I understand that my records may contain information regarding diagnosis or treatment of mental illness, psychiatric treatment, drug and/or alcohol abuse, HIV/AIDS, or sexually transmitted diseases. I give my specific authorization for these records to be released. I understand my rights listed below.

_____ **Date signed:** _____

Signature of patient if over 13 years of age

*To exclude any of the following information from the records to be released please initial:

___ Mental Illness or Psychiatric diagnosis/treatment ___HIV/AIDS diagnosis/treatment/testing

___Drug Alcohol abuse/treatment &diagnosis ___Sexually transmitted diseases

Signature _____ **Date signed:** _____

Parent or legally authorized individual

Printed Name: _____ **Relationship to Patient:** _____

Note: All records will be destroyed after 6 months if patient has not established care in our office.